ADVANCING PARTNERS & COMMUNITIES

COUNTRY PROFILE: ETHIOPIA

ETHIOPIA COMMUNITY HEALTH PROGRAMS
DECEMBER 2013

USAID FROM THE AMERICAN PEOPLE

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Advancing Partners & Communities (APC) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute in collaboration with FHI 360. The project focuses on advancing and supporting community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. APC provides global leadership for community-based programming, executes and manages small- and medium-sized sub-awards, supports procurement reform by preparing awards for execution by USAID, and builds technical capacity of organizations to implement effective programs.

Recommended Citation
Advancing Partners & Communities. 2013. *Country Profile: Ethiopia Community Health Programs*. Arlington, VA: Advancing Partners & Communities.

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COUNTRY PROFILE*

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This publication was produced by Advancing Partners & Communities (APC), a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. The authors' views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the United States Government.

* Adapted from the Health Care Improvement Project's *Assessment and Improvement Matrix* for community health worker programs, and PATH's Country Assessments of Community-based Distribution programs.

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ACRONYMS

AIDS	acquired immunodeficiency syndrome
BCC	behavior change communication
CHP	Community Health Promoters initiative
CHW	community health worker
DMPA (IM)	Intramuscular Depo-Provera
ESHE	Ethiopia Essential Services for Health Project
FAM	fertility awareness method
FP	family planning
HDA	Health Development Armies
HEP	Ethiopia Health Extension Program
HEW	health extension workers
HIV	human immunodeficiency virus
HMIS	health management information system
ICCM	integrated case management of childhood illnesses
IEC	information, education, and communication
IRS	indoor residual spraying
IUD	intrauterine device
MCH	maternal and child health
MNH	maternal and newborn health
MOH	Ministry of Health
NGO	nongovernmental organization
ORS	oral rehydration salts
PMTCT	prevention of mother-to-child transmission (of HIV)
PPH	postpartum hemorrhage
SDM	standard days method
SP	sulphadoxine-pyrimethamine (for treatment of uncomplicated malaria)
UHEP	Ethiopia Urban Health Extension program
UHE-Ps	Urban Health Extension Professionals
VCT	voluntary counselling and testing

I. INTRODUCTION

This Country Profile is the outcome of a landscape assessment conducted by Advancing Partners & Communities (APC) staff and colleagues. The landscape assessment focused on the United States Agency for International Development (USAID) Population and Reproductive Health priority countries, and includes specific attention to family planning as that is the core focus of the APC project. The purpose of the landscape assessment was to collect the most up to date information available on the community health system, community health workers, and community health services in each country. This profile is intended to reflect the information collected. Where possible, the information presented is supported by national policies and other relevant documents; however, much of the information is the result of institutional knowledge and personal interviews due to the relative lack of publicly available information on national community health systems. As a result, gaps and inconsistencies may exist in this profile. If you have information to contribute, please submit comments to info@advancingpartners.org. APC intends to update these profiles regularly, and welcomes input from our colleagues.

II. GENERAL INFORMATION

1	What is the name of this program*, and who supervises it (Government, nongovernmental organizations (NGOs), combination, etc.)? *Please list all that you are aware of.* **If there are multiple programs, please add additional columns to the right to answer the following questions according to each community health program.*	The Ethiopia Health Extension Program (HEP) has 31,000 Health Extension Workers in rural areas throughout the country. HEP is the Government of Ethiopia's Program, which is supported by multiple donor-funded programs.	The Ethiopia Urban Health Extension program (UHEP) is the government of Ethiopia's initiative to provide equitable health services to the urban population of Ethiopia. More than 4,000 nurses were trained and deployed to small and big cities or towns across the country. The Government of Ethiopia supervises the program.

2	How long has this program been in operation? What is its current status (pilot, scaling up, nationalized, non-operational)?	The HEP program officially started in 2003. Its antecedent was the Ethiopia Essential Services for Health (ESHE) Project implemented from 2000 to 2008. ESHE introduced the Community Health Promoters (CHP) initiative, which used volunteers selected by the community, or Kebele, (a population of 5,000) to provide health services at the community level. One CHP served 20 to 30 households. The Government of Ethiopia launched a nationwide HEP in 2003, which is fully institutionalized and run by salaried health extension workers (HEWs).	UHEP started in 2009. It is modeled on the Health Extension Program with some modifications. It is currently being implemented in more than 400 small and big cities/towns.
3	Where does this program operate? Please note whether these areas are urban, peri-urban, rural, or pastoral. Is there a focus on any particular region or setting? *Please note specific districts/regions, if known.*	HEP operates nationwide in the rural and pastoral areas of Ethiopia.	UHEP operates in five urban and peri-urban regions (Tigray, Amhara, Oromia, SNNP, Harari) and two city administrations (Addis Ababa and Dire Dawa). The program was also initiated in Gambella, but the current status is not known. The program has yet to be initiated in Afar, Benishangul, and Somali regions.
4	If there are plans to scale up the community health program, please note the scope of the scale-up (more districts, regional, national, etc.) as well as location(s) of the planned future implementation sites.	HEP is already national in scope. However, there are several new aspects or sub-components of the program that are being scaled up. For example the integrated case management of childhood illnesses (ICCM), nutrition education, insertion of implants and maternal health are all in various stages of being piloted and scaled up. In addition, some geographical areas are stronger than others, and efforts are being made to improve the quality of services, particularly in pastoralist areas.	UHEP is quite different from HEP because of the complexities in urban areas. Standardization across the nation and even one region or city is challenging due to the diverse target groups and complex health problems that have to be dealt with. Overall, the program covers the bigger regions and City Administrations with features of urbanization. There is no defined plan for scale-up. However, small regions are also showing a lot of interest to start the program. As interest grows, the program will be implemented in those regions.

5	Please list the health services delivered by community health workers (CHWs[1]) under this program. Are these services part of a defined package? Do these services vary by region?	The services delivered are a part of a defined package. However, this package has evolved with time. There is regular analysis and study of the package and its effectiveness. Services in the current full package include: • Hygiene and environmental sanitation • Community mobilization • Model families • Support to immunization • Family planning • ICCM • Malaria • Maternal health • Tracking pregnant women, referral for prevention of mother-to-child transmission (of HIV) (PMTCT), and assisted deliveries • Nutrition education • Adolescent reproductive health • Behavior change communication (BCC) • Training and working with Health Development Army volunteers • Identification and referral of possible cases of vaginal fistula	There is a defined package of services for UHEP. Originally, the service package was a copy from the HEP. A number of challenges were faced in terms of implementation because of this. The services that are currently being provided by UHEP vary across regions and cities. The program focuses on prevention, health promotion, and selected curative services targeting urban dwellers at households, youth centers, and schools, with strong referral linkages to health facilities. The urban health extension professionals (UHE-Ps) are responsible for delivering up to 15 services with a focus on four major health program components: • Hygiene and environmental sanitation • Family health care • Prevention and control of communicable and non-communicable diseases • Injury prevention and control, first aid, and referral and linkage The specific services provided in an urban community are meant to be specifically targeted to that community, so not all UHE-Ps will deliver the same services.
6	Are family planning (FP) services included in the defined package, if one exists?	Yes, the HEP provides a wide range of family planning services. It includes all methods, except intrauterine devices (IUDs) and sterilization. Referrals are made to health centers for IUDs and hospitals for sterilization. Selected CHWs do community-based insertion of implants. Abortion referrals are also included; abortion is legal in Ethiopia, although CHWs do not perform abortions.	Yes, family planning services are included in the program. However, the focus is on education, counseling, and referral rather than provision of services due to health facilities being geographically accessible in urban areas. In some regions, UHE-Ps also provide family planning commodities, including the provision of oral and injectable contraceptives.

[1]The term "CHW" is used as a generic reference for community health workers for the purposes of this landscaping exercise. Country-appropriate terminology for community health workers is noted in the response column.

7	Please list the family planning services and methods delivered by CHWs.	• Counseling and education • Condoms • Oral pills • Injectable contraceptive provision • Contraceptive implants provision (limited) • Referrals for IUDs, sterilization and abortion • Limited counseling for adolescents • Training of Health Development Army (HDA) in family planning mobilization	• Counseling and education • Condom provision • Training of community groups (such as Health Development Army) • Referrals In some regions and cities/towns they also provide oral pills and injectable contraceptives, but this is not standardized or in the defined package of services.
8	What is the general service delivery system (e.g. how are services provided? Door-to-door, via health posts/other facilities, combination)?	Most services are provided at local health posts. However, some household visits are expected by HEWs, particularly to post-partum women and newborns.	The general service delivery system of UHEP is at household, schools, and youth centers. However, the implementation at schools and youth centers is not systematically implemented at this time.

III. COMMUNITY HEALTH WORKERS

9	Are there multiple cadre(s) of health workers providing services at the community level? If so, please list them by name and note hierarchy.	The only official cadre of CHW in rural areas is the **HEW**. A new cadre of volunteers is the **HDA**, which is a group of five heads of households in a community. These volunteers are jointly trained and supervised by health centers and HEWs. They are volunteers who trace pregnant women, motivate and educate their communities, and participate in many ways in the primary health care system in Ethiopia.		The official cadres of CHW in urban areas of Ethiopia are the **UHE-Ps**. The UHEP also is supported by **HDAs**. In UHEP, Urban HDAs are comprised of up to 30 households residing in the same neighborhood. The HDA is further divided into smaller groups of six members, commonly referred as "one-to-five networks." Additionally, there are also diverse cadres of volunteers supported by many local and international NGOs.	
10	Do tasks/responsibilities vary among CHWs? How so (by cadre, experience, age, etc.)?	HEWs provide a standard set of services based on the defined package of services. However, some HEWs also provide additional services such as deliveries, implant insertions, or ICCM, depending on whether or not they have completed additional specialized trainings. Eventually all HEWs will be trained in these areas. HDAs provide a more limited scope of services due to less training.		All UHE-Ps have the same job description and responsibilities. However, due to the infancy of the program there is a lack of standardization across cities and towns leading to differing responsibilities across UHE-Ps. There is also an intention to target specific services in communities based on need, so not all UHE-Ps will provide the same services. Urban HDAs provide a more limited scope of services due to less training.	
11	Total number of CHWs in program? *Please break this down by cadre, if known, and provide goal and estimated actual numbers. Please note how many are active/inactive, if known.*	**HEW** There are approximately 30,000 HEWs. There is good attrition of HEWs. They are replaced by periodic trainings of new HEWs.	**HDA** When scaled, there will be 200 HDA volunteers per 5,000 people.	**UHE-P** Currently there are more than 4,000 UHE-Ps.	**Urban HDA** Not currently tracked, as there is no system in place to monitor the large number of urban HDA

12	Criteria for CHWs (e.g. age, gender, education level, etc.)? *Please break this down by cadre, if known.*	**HEW** Must have a 10th grade education. They are virtually all female.	**HDA** Selected as a result of being model families within the community.	**UHE-P** Must be female, be a diploma nurse, and be a resident of the city for which they are recruited for.	**Urban HDA** The leaders of the HDAs and the one-to-five networks are selected by HDA team members. The main criteria for selection of the leaders are being a model family and trust by the members in mobilizing the community.
13	How are the CHWs trained? Please note the length, frequency, and requirements of training. *Please break this down by cadre, if known.*	**HEW** Receive an initial training lasting 10 months. After the completion of this training, they attend regular in-service training and training for new types of services.	**HDA** Information unavailable	**UHE-P** Receive three months of pre-service training to equip them with public health knowledge and skills. This is in addition to their nurse training. The pre-service training focuses on the 15 packages of services delivered. They are also provided with in-service training by different NGOs, though this is not part of the standard UHEP training.	**Urban HDA** Information unavailable
14	Do the CHWs receive comprehensive training for all of their responsibilities at once, or is training conducted over time? How does this impact their ability to deliver services?	**HEW** Receive an initial training and then are trained on additional health services as trainings evolve and become available. In its initial stages, HEWs were trained to do community mobilization, especially in water and sanitation. Other services such as immunizations, family planning services,	**HDA** Information unavailable	**UHE-P** Receive a three-month comprehensive training. Some UHE-Ps receive additional in-service training from NGOs, however this is not standardized.	**Urban HDA** Information unavailable

		ICCM, and maternal health have been added over time. The amount of training, which takes workers from their sites, has been recognized as an issue within communities. Thus, the program is moving towards an integrated management scope that will reduce time away from their health posts.			
15	Please note the health services provided by the various cadre(s) of CHW, as applicable (i.e. who can provide what service).	**HEW** Environmental sanitation; health and nutrition education; pre and postnatal care; family planning; child health including, immunization, treatment of pneumonia, diarrhea, and rapid diagnosis and treatment of malaria; community mobilization. Some HEWs also do deliveries, although the current policy of the government does not encourage this.	**HDA** Community mobilization, family planning information	**UHE-P** Prevention, health promotion, and basic curative service for hygiene and environmental sanitation, family health care, prevention and control of communicable and non-communicable diseases, injury prevention and control, first aid, and referral and linkage to services.	**Urban HDA** Information unavailable

16	Please list which family planning services are provided by which cadre(s), as applicable. Provide information, counseling, provision of condoms and refer for the services. In some cities and towns UHE-Ps are providing oral pills and injectables.		**HEW**	**HDA**	**UHEP**	**Urban HDA**
		Information/education	Standard days method (SDM)/fertility awareness method (FAM), condoms, oral pills, injectables, implants, IUDs, permanent methods, and emergency	Condoms, oral pills, injectables, implants, IUDs, and permanent methods	Condoms, oral pills, injectables, implants, IUDs, and permanent methods	Condoms, oral pills, injectables, implants, IUDs, and permanent methods

			contraception			
		Method counseling	SDM/FAM, condoms, oral pills, injectables, implants, IUDs, permanent methods, and emergency contraception	Not applicable	Condoms, and sometimes oral pills and injectables. Provision of oral pills and injectables is not part of their service package, but does occur in some communities.	Not applicable
		Method provision	SDM/FAM condoms, oral pills, injectables, implants (some HEWs), and emergency contraception	Not applicable	Condoms	Not applicable
		Referrals	Implants, IUDs, and permanent methods	SDM/FAM, condoms, oral pills, injectables, implants, IUDs, permanent methods, and emergency contraception	SDM/FAM, condoms, oral pills, injectables, implants, IUDs, and permanent methods	SDM/FAM, condoms, oral pills, injectables, implants, IUDs, and permanent methods
17	Do CHWs distribute commodities in their communities (zinc tablets, FP methods, etc.)? Which programs/products?	**HEW** Contraceptives, including natural family planning, condoms; oral pills; implants (limited); injectables; vaccines; anti-malarials; chlorhexidine; antibiotics; oral rehydration salts (ORS); zinc; misoprostol for postpartum hemorrhage; and other medicines.	**HDA** HDAs do not distribute commodities.	**UHE-P** In some locations UHE-Ps distribute vitamin A, condoms, oral pills, and injectables.	**Urban HDA** Information unavailable	
18	Are CHWs paid, are incentives provided, or are they volunteers? *Please differentiate by cadre, as*	**HEW** HEWs are paid by the Government of Ethiopia and considered government	**HDA** HDAs are volunteers.	**UHE-P** UHE-Ps are civil servants and are on the Government	**Urban HDA** HDAs are volunteers.	

	applicable.	employees. Additional incentives are non-formal and include training and respect from the community.		of Ethiopia payroll.	
19	Who is responsible for these incentives (MOH, NGO, municipality, combination)?	The Ministry of Health (MOH) through Regional Health Offices, District Health Offices, Woreda Health Offices, and health centers provide most of the support for HEWs, including payment. However, NGO or other donor-assisted programs work extensively with these programs and frequently subsidize review meetings, training, some information, education, and communication (IEC)/BCC materials, and other informal incentives.		The MOH, Regional Health Offices, and the municipality are responsible for payment and incentives.	
20	Do CHWs work in urban and/or rural areas?	**HEW** Rural and pastoral	**HDA** Rural and pastoral	**UHE-P** Urban	**Urban HDA** Urban
21	Are CHWs residents of the communities they serve? Were they residents before becoming CHWs (i.e. are they required to be a member of the community they serve)?	**HEW** HEWs are residents of the village or area where they work. For this reason it is more difficult to employ HEWs in pastoralist communities because of low literacy, and cultural and language barriers.	**HDA** HDAs are current residents of the community in which they live.	**UHE-P** UHE-Ps are supposed to be residents of their communities. However, in practice the nurses often come from different areas.	**Urban HDA** HDAs are current residents of the community in which they live.
22	Describe the geographic coverage/catchment area for each CHW.	**HEW** Two HEWs serve as a team working at one health post. Each health post serves an average of 5,000 people. Thus, each HEW is roughly responsible for 2,500 individuals.	**HDA** Each HDA will serve 25 people. Each team of HDAs will be made up of 200 people and will serve a total of 5,000 people.	**UHE-P** One UHE-P serves 500 households.	**Urban HDA** Information unavailable
23	How do CHWs get to their clients (walk, bike, public transport, etc.)?	**HEW** HEWs walk to their clients' homes. Clients also visit	**HDA** Information unavailable	**UHE-P** UHE-Ps walk to their clients homes. Clients can also visit them in youth centers and	**Urban HDA** Information unavailable

		them in the health post.		schools. UHE-Ps only provide services and commodity distribution in households. Some UHE-Ps have received bicycles through donor funds.	
24	Describe the CHW role in data collection and monitoring.	**HEW** HEWs are the first tier of the national health management information system (HMIS) system. Family Folders with comprehensive health information completed for each household are kept at health posts. The system used by HEWs is still largely manual, but there is experimentation with mHealth and other HMIS interventions, such as expanded Data for Decision Making training at the Woreda and health center levels. There are regular review meetings where data are compared and analyzed.	**HDA** Information unavailable	**UHE-P** The UHE-Ps have data recording and reporting formats. However, the formats are not standardized and are not linked to the national HMIS system. Linking the data of the UHEP with the national HMIS and use of data for decision making is planned in the next few years.	**Urban HDA** Information unavailable

IV. MANAGEMENT AND ORGANIZATION

25	Does the community health program have a decentralized management system? If so, what are the levels (state government, local government, etc.)?	The HEP is a semi-decentralized system. Both HEWs and HDAs are managed under this system. • Central • Regional • District • Woreda (local)	The UHEP is a semi-decentralized system. Both UHEPs and Urban HDAs are managed under this system. • Central • Regional • District • Municipality
26	Is the MOH responsible for the program, overall?	Yes, the Federal Ministry of Health is responsible for the program. Though many local and international NGOs are involved in the HEP, all must follow the government health policy.	The Federal Ministry of Health is overall responsible for the UHEP program. The regional health bureaus also can make some decisions based on the context of their region.
27	What level of responsibility do regional, state, or local governments have for the program, if any? *Please note responsibility by level of municipality.*	Policy and leadership is at the central level, but day-to-day management is from the regional, district, and Woreda levels. There are regular review meetings at every level, including an annual national review and planning meeting.	The municipality is responsible for the implementation of the program. The MOH develops policies and guidelines. Regional Health Bureaus are supposed to contextualize the policies, strategies, and guidelines and translate them for their local context. The day-to-day management occurs at the municipalities' health departments and offices.
28	What level of responsibility do international and local NGOs have for the program, if any?	The HEP is dominated by the public sector, with a few NGOs and international NGOs playing a technical assistance role. Local NGOs are mostly involved in specialized areas (e.g. youth reproductive health, nutrition). Faith-based organizations run some health facilities. International NGOs are mostly involved in technical support, operations research, or support for a specific program areas.	The UHEP program is directly managed by the Government of Ethiopia and therefore NGOs are not responsible for the program's success. However, some NGOs support UHE-Ps by providing additional in-service trainings.
29	Are CHWs linked to the health system? Please describe the mechanism.	HEWs are directly linked to the health system as they offer services at the lowest level of the health system. Additionally, they are supervised by health center staff and paid by the Government of Ethiopia. The health posts operated by HEWs are also the lowest level of facility-based care in the national health system.	UHE-Ps are linked to the national health system, though to a lesser degree than the HEWs since the program is so new. A standardized model for linking UHE-Ps to the overall health system is in development. Officially, UHE-Ps are meant to report to health centers, with administrative reporting to the Health Office, but this system is still being established.

30	Who supervises CHWs? What is the supervision process? Does the government share supervision with an NGO/NGOs? If so, please describe how they share supervision responsibilities.	HEWs are supervised by medical professionals at health centers. One health center supervises approximately five health posts, or 10 HEWs. The modalities vary. Some health center supervisors regularly visit the health posts; in other cases HEWs come to the health center. The HDA is supervised by the HEWs. Supervision occurs regularly at the health post. There are periodic supervision visits by Woreda or District Health Offices for both HEWs and HDAs, often accompanied by an NGO that provides technical support.		The UHE-Ps are supervised by UHEP supervisors who sit either at the health centers or the town or city health offices. However, there are many more UHE-Ps than health centers in each city or town, making it difficult for health center staff to supervise all UHE-Ps. The Urban HDAs are supervised by the UHE-Ps. Supervision occurs regularly and is monitored by the health center.
31	Where do CHWs refer clients for the next tier of services? Do lower level cadres refer to the next cadre up (of CHW) at all?	HEWs refer difficult cases to health centers. Referrals are made using specific referral forms. HDAs mobilize community members to visit the health posts and HEWs.		The UHE-Ps refer to both public and private health facilities. HDAs mobilize community members to obtain medical care through UHE-Ps and public and private health facilities.
32	Where do CHWs refer clients specifically for FP services? *Please note by method.*	*Condoms*	Not applicable	Not applicable
		Oral pills	Health center for complications	Public and private health facilities
		IUD	Health center	Public and private health facilities
		Intramuscular Depo-Provera (DMPA)	Health center for complications	Public and private health facilities
		Implants	Health center. For those HEWs inserting implants, referrals are made to health centers for removal.	Public and private health facilities
		Permanent methods	Health center	Public and private health facilities
		Emergency contraception	Health center for complications	Public and private health facilities
33	Are CHWs linked to other community outreach programs?	The HDAs provide significant outreach at the community level. NGOs also participate in outreach services.		The UHEP program is considered an outreach program. However, it is not well linked to the other outreach programs.

34	What mechanisms exist for knowledge sharing among CHWs/supervisors?	The program has many manuals, IEC/BCC materials, mapping of each community and job aides. The distribution is tracked and these are periodically updated. HEWs and their supervisors also come together for periodic review meetings and trainings, and through supervision or exchange visits.	There are supposed to be monthly meetings between the health centers and the UHE-Ps though it is not regularly done. City level review meetings are also conducted. Meetings between the UHE-Ps and UHEP supervisors are supposed to be conducted every week (Friday). There is a plan to implement information sharing between UHE-Ps in the coming few years.
35	What links exist to other institutions (schools, churches, associations, etc.)?	The HEP is linked to specialized hospitals, societies (e.g. cancer), and benevolent groups. Additionally, churches and associations are collaborating with HEWs in the promotion of preventive and educational health outreach, including family planning and environmental sanitation.	The UHEP program is linked to private sector programs.
36	Do vertical programs have separate CHWs or "share/integrated"?	The HEP is an integrated program.	The UHEP is an integrated program.
37	Do they have data collection/reporting systems?	There is national-scale reporting completed through an HMIS system. Data collected by HEWs are incorporated into this system.	UHEP has data collection mechanisms; however the system is not yet standardized across Ethiopia due to its infancy.
38	Describe any financing schemes that may be in place for the program (e.g. donor funding/MOH budget/municipal budget/health center user fees/direct user fees).	The Government of Ethiopia pays HEWs and other MOH staff through its own budget and some donor support. New financing schemes are being tested. For example user fees for non-primary health care interventions are used at the health center level to finance programs.	The Government of Ethiopia pays the salaries of UHEPs. Funds for training and other expenses have been supported through donor funds.
39	How and where do CHWs access the supplies they provide to clients (medicines, FP products, etc.)?	Most HEWs access supplies from health centers. Some health posts receive supplies directly from the national supply management system.	UHE-Ps access supplies from the health centers. In some areas, NGOs provide supplies directly to UHE-Ps, though this system is not preferred by the MOH.
40	How and where do CHWs dispose of medical waste generated through their services (used needles, etc.)?	HEWs receive training in medical waste disposal. Pits are the main disposal method used as there are no incinerators at health posts.	UHE-Ps do not generate medical waste. However, if waste is generated it is collecting using a safety box and disposed of at the health centers.

V. POLICIES

41	Is there a stand-alone community health policy? If not, is one underway or under discussion? *Please provide a link if available online.*	There is no stand-alone community health policy.
42	Is the community health policy integrated within overall health policy?	Both community health programs are integrated into the overall health policy of the Ministry of Health. Community health is the backbone of the primary health care system. The country's health policy is prevention-focused and the HEP (both HEP and UHEP) was designed to ensure its implementation.
43	When was the last time the community health policy was updated? (months/years?)	The country has only one health policy that was developed in the 1990's. It is updated every year at a national meeting with new strategies and plans. Recent updates include addition of ICCM (community case mgmt.), a new maternal and newborn health (MNH) focus (as of 2012), and a new newborn care initiative.
44	What is the proposed geographic scope of the program, according to the policy? (Nationwide? Select regions?)	The health policy denotes services should be offered nationwide; however there is no specific policy for community health.
45	Does the policy specify which services can be provided by CHWs, and which cannot?	Yes. The overall health policy denotes services to be provided by the HEP. The UHEP has implementation manuals noting which services should be provided; this has not been incorporated into the health policy to date.
46	Are there any policies specific to FP service provision (e.g. CHWs allowed to inject contraceptives)?	Yes, The National Guideline for Family Planning Services in Ethiopia 2011 states that HEWs are not able to provide IUD insertion or implant removals. UHE-Ps are supposed to provide information, education, counseling, and condoms. They are not supposed to provide other services; however, in some areas they provide oral pills and injectable contraceptives.

VI. INFORMATION SOURCES

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VII. AT-A-GLANCE GUIDE TO ETHIOPIA COMMUNITY HEALTH SERVICE PROVISION

Intervention		Health Extension Workers				Health Development Army			
Family Planning	*Services/Products*	*Information/ education*	*Counseling*	*Administered and/or provided product*	*Referral*	*Information/ education*	*Counseling*	*Administered and/or provided product*	*Referral*
	SDM/FAM	X	X	X		X			X
	Condoms	X	X	X		X			X
	Oral pills	X	X	X		X			X
	DMPA (IM)	X	X	X		X			X
	Implants	X	X	X (limited)	X (for removal only in limited areas)	X			X
	IUDs	X	X		X	X			X
	Permanent methods	X	X		X	X			X
	Emergency Contraception	X	X	X		X			X
HIV/AIDS	Voluntary counselling and testing (VCT)	X	X		X	X			X
	PMTCT	X	X		X	X			X

Maternal and Child Health (MCH)	Misoprostol (for prevention of postpartum hemorrhage - PPH)	X	X	X		X			X
	Zinc	X	X	X		X			X
	ORS	X	X	X		X			X
	Immunizations	X	X	X		X			X
Malaria	Bed nets	X	X	X		X			X
	Indoor residual spraying (IRS)	X	X	X		X			X
	Sulphadoxine-pyrimethamine (for treatment of uncomplicated malaria) (SP)	X	X	X		X			X

Intervention		Urban Health Extension Professionals				Urban Health Development Army			
Family Planning	*Services/Products*	*Information/ education*	*Counseling*	*Administered and/or provided product*	*Referral*	*Information/ education*	*Counseling*	*Administered and/or provided product*	*Referral*
	SDM/FAM	X			X	X			X
	Condoms	X		X	X	X			X
	Oral pills	X			X	X			X
	DMPA (IM)	X			X	X			X
	Implants	X			X	X			X
	IUDs	X			X	X			X
	Permanent methods	X			X	X			X
	Emergency contraception								
HIV/AIDS	VCT								
	PMTCT								
MCH	Misoprostol (for prevention of postpartum hemorrhage - PPH)								
	Zinc								
	ORS								
	Immunizations								
Malaria	Bed nets								
	IRS								

	SP								

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